MIAMI-DADE COUNTY

CORRECTIONS AND REHABILITATION DEPARTMENT

ORIENTATION INTERVIEW QUESTIONNAIRE

NAME: _____ **LATERAL: YES** _____

SS#: _____ **NO** _____

ORIENTATION DATE: _____

1) Do you have an open investigation at this present time? _____

2) Have you ever been rejected for employment by a law enforcement agency? When and how many times? _____

3) Has disciplinary action ever been taken against you? Have you been involved in any grievance procedures? _____

4) Have you used any illegal drugs within the past three (3) years? _____

5) What is the current status of your certification? _____

6) Have you ever been terminated or forced to resign from a job? _____

7) Has a license or certificate issued to you, ever been suspended or revoked? _____

8) Have you ever been disciplined while in the military? _____

"DELIVERING EXCELLENCE EVERY DAY"

MIAMI-DADE
CORRECTIONS AND REHABILITATION DEPARTMENT
MIAMI-DADE COUNTY, FLORIDA
PERSONNEL BUREAU

I. RESIDENCY REQUIREMENT

In accordance with the provisions of Section 2-11.17 of the Code of Miami-Dade County, applicants must agree to establish and maintain permanent residence in Miami-Dade County within fifteen (15) months of employment from the original appointment date. **All sworn classifications within the Corrections & Rehabilitation Department are exempt from the residency requirement.**

All employees of Miami-Dade County hired on or after February 14, 1998, shall maintain their domicile and principal place of residence within the corporate limits of Miami-Dade County during the period of their employment with Miami-Dade County. Any employee that does not at all times during such employment maintain his or her domicile and principal place of residence in Miami-Dade County may be dismissed from County service.

II. HOURS OF OPERATION

The Miami-Dade Corrections and Rehabilitation Department operates 24 hours, 7 days per week. As such, I acknowledge that my shift assignment and days off will be based on departmental needs. I agree to work weekdays, weekends, and holidays, or any assigned shift such as, but not limited to, day (7:00 a.m. x 3:00 p.m.), afternoon (3:00 p.m. x 11:00 p.m.), midnight (11:00 p.m. x 7:00 a.m.), and/or variable (8:00 a.m. x 5:00 p.m.).

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD AND AGREED TO COMPLY WITH THE MIAMI-DADE COUNTY RESIDENCY REQUIREMENT PROVISIONS OF SECTION 2-11.17 AND THE HOURS OF OPERATION AS TERMS AND CONDITIONS OF EMPLOYMENT WITH THE CORRECTIONS AND REHABILITATION DEPARTMENT.

_____	_____	_____
Applicant Name (PLEASE PRINT)	Date	Applicant Signature
_____	_____	**Investigator**
Witness, Corrections and Rehabilitation Personnel Bureau Staff Member	Date	Title

"DELIVERING EXCELLENCE EVERY DAY"

TO: Social Security Administration
1801 Alton Road, Suite 200
Miami Beach, Florida 33139

FAX: (305) 531-5228

Name	**Date of Birth**	**Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

MIAMI-DADE COUNTY
CORRECTIONS & REHABILITATION DEPARTMENT

FROM: _____

Personnel / Management Bureau
2525 NW 62nd Street , Suite 2000
Miami, Florida 33147
(786) 263-6000 Fax: (786) 263-6127

I want this information released because:

Law Enforcement Background Investigation for employment

(There may be a charge for releasing information)

Please release the following information:

_____	**Social Security Number**
_____	**Identifying information (includes date and place of birth, parents' name)**
_____	**Monthly Security benefit amount**
_____	**Monthly Supplemental Security Income payment amount**
_____	**Information about benefits/payments I received from _____ to _____**
_____	**Information about my Medicare claim/coverage from _____ to _____**
	(specify) _____
_____	**Medical Records**
XX	**Record(s) from my file (specify)** History of my earnings and employers
_____	**Other (specify) _____**

I am the individual to whom the information/record applies or the parent or legal guardian of that person. I know that if I make any representation, which I know is false to obtain information from Social Security records, I would be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark)

Date: _____ Relationship: _____

Form SSA-3288 (2-1991) EF (1-2001)

MIAMI-DADE COUNTY

CORRECTIONS AND REHABILITATION DEPARTMENT

ATTESTATION OF NON-SERVICE

I, _____, do hereby attest that I have never been a member of the Armed Forces of the United States and have never received a dishonorable or undesirable discharge from my branch of the military services.

Signed: _____

Date: _____

FDLE
Florida Department of
Law Enforcement

AUTHORITY FOR RELEASE OF INFORMATION
(Background Investigation Waiver)

Incorporated by Reference in Rule 11B-27.0022(2)(b), F.A.C.

CJSTC 58

To: Concerned Person or Authorized Representative of Any Organization, Institution or Repository of Records

APPLICANT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER (Optional): _____

EMPLOYING AGENCY REQUESTING BACKGROUND INFORMATION: _____

I hereby authorize any employee or authorized representative bearing this release, or copy thereof, to obtain any information in your files pertaining to my employment records including, but not limited to, achievement, attendance, personal history, disciplinary records, medical records, credit records, and criminal history records. I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the requesting agency. Consent is granted for the agency to furnish such information, as is described above, to third parties in the course of fulfilling its official responsibilities. I hereby release you, as the custodian of such records, and employer, educational institution, physician, hospital or other repository of medical records, credit bureau or consumer reporting agency, including its officers, employees, and related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information, or any attempt to comply with it. A photocopy of this form will be as effective as the original.

I hereby authorize the National Records Center, St. Louis, Missouri, or other custodian of my military record to release information or photocopies from my military personnel and related medical records, including a photocopy of my DD 214, Report of Separation, to:

_____

768.095, F.S., titled Employer Immunity from Liability; disclosure of information regarding former employees states: An employer who discloses information about a former employee's job performance to a prospective employer of the former employee upon request of the prospective employer or of the former employee is presumed to be acting in good faith and, unless lack of good faith is shown by clear and convincing evidence, is immune from civil liability for such disclosure of its consequences. For the purposes of this section, the presumption of good faith is rebutted upon a showing that the information disclosed by the former employer was knowingly false or deliberately misleading, was rendered with malicious purpose, or violated any civil right of the former employee protected under chapter 760. ***Pursuant to Sections 943.134(2)(a) and (4), F.S., Chapter 2001-94, Laws of Florida, disclosure of information is required unless contrary to state or federal law. Civil penalties may be available for refusal to disclose non-privileged legally obtainable information.***

_____ _____

Applicant's Signature **Date**

_____

Applicant's Address

AFFIDAVIT

STATE OF _____ **COUNTY OF** _____

Before me personally appeared _____ who says that he/she executed the above instrument of his or her own free will and accord, with full knowledge of the purpose therefore.

Sworn and subscribed in my presence this _____ day of _____, 20_____. My Commission expires on _____, 20_____. Personally Known _____ - or -

Produced Identification _____ Notary Public: _____

Type of identification produced: _____

MIAMI-DADE COUNTY

CORRECTIONS AND REHABILITATION DEPARTMENT

AFFIDAVIT OF CRIMINAL HISTORY DISCLOSURE

Have you ever been arrested, received a notice to appear, charged, convicted, pled nolo contendere or plead guilty to any criminal violation (including traffic and juvenile), regardless if the record was sealed, expunged or a pardon was granted. _____ Yes _____ No _____
Initials

Florida State Statute 943.058 (4)(a) **Court Ordered Expunction of Criminal History Records** states in part, when all criminal history records, except for records retained under seal by the Courts or Department of Law Enforcement, have been expunged, the subject of such records may lawfully deny or fail to acknowledge the events covered under expunged or sealed records, **except in the following circumstances:**

1) "When the person who is the subject of the record is a candidate for Employment with a criminal justice agency;"

This exception requires by law that you, as an applicant for employment with a criminal justice agency (such as Miami-Dade Corrections and Rehabilitation Department), must not deny or fail to acknowledge the events in any expunged or sealed record(s).

A denial or failure to acknowledge the events in any expunged or sealed records in this exception will result in rejection based on falsification of your application, or termination and possibly de-certification, if already employed.

I have read and understand all of the above information.

Applicant's Name (please print) :_____

Applicant's Signature: _____ Date: _____

"DELIVERING EXCELLENCE EVERY DAY"

Standard Form 180 (Rev. 10-05) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 9/30/2008

REQUEST PERTAINING TO MILITARY RECORDS

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type. If you need more space, use plain paper.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATES OF SERVICE		CHECK ONE		SERVICE NUMBER DURING THIS PERIOD (If unknown, write "unknown")
		DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	
a. ACTIVE SERVICE						
b. RESERVE SERVICE						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. **REPORT OF SEPARATION** (DD Form 214 or equivalent). This contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one Report of Separation. Be sure to show EACH year that a Report of Separation was issued, for which you need a copy.

☐ An **UNDELETED** Report of Separation is requested for the year(s) _____

This normally will be a copy of the full separation document including such sensitive items as the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost. An undeleted version is ordinarily required to determine eligibility for benefits.

☐ A **DELETED** Report of Separation is requested for the year(s) _____

The following information will be deleted from the copy sent: authority for separation, reason for separation, reenlistment eligibility code, separation(SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

2. **OTHER INFORMATION AND/OR DOCUMENTS REQUESTED** _____

3. **PURPOSE** (Optional – An explanation of the purpose of the request is strictly voluntary. Such information may help the agency answering this request to provide the best possible response and will in no way be used to make a decision to deny the request.) _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:**

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran _____ (relation)
☐ Legal guardian (must submit copy of court appointment)
☐ Other (specify) _____

2. **SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 3 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. **AUTHORIZATION SIGNATURE REQUIRED** *(See item 2 on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature (Please do not print.)

Date of this request ( ) Daytime phone

Email address

** This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.**

MIAMI-DADE CORRECTIONS & REHABILITATION DEPARTMENT

EMPLOYEE APPEARANCE STANDARD

PERSONAL GROOMING

- ❑ **FACIAL HAIR**
- ❑ **FINGERNAILS**
- ❑ **HAIRSTYLES**
- ❑ **MAKE-UP**

JEWELRY

- ❑ **BRACELETS**
- ❑ **EARRINGS**
- ❑ **NECKWEAR**
- ❑ **NOSE DECORATION AND BODY PIERCING**
- ❑ **RINGS**
- ❑ **TATTOOS**
- ❑ **TEETH DECORATIONS**

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE REVIEWED, UNDERSTAND AND AGREE TO COMPLY WITH THE PERSONAL GROOMING STANDARDS OF DSOP 6-017.

Print Name	Signature	Date
Witness, Corrections and Rehabilitation Personnel Bureau Staff Member	Investigation Specialist I Title	Date